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SUBMISSION TO THE

HEALTH CARE COMMITTEE

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL

ON THE

EFFECTS OF PASSIVE SMOKING ON HEALTH

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1.0 THE HEALTH EFFECTS OF PASSIVE SMOKING

It has been known for over forty years that active smoking is a cause of disease in the smoker. Conclusive evidence that the inhalation of other people's tobacco smoke, or passive smoking, can be harmful to health, has accumulated in the past twenty years. Evidence that passive smoking caused respiratory illness in young children emerged during the 1970s[1],[2],[3], and studies demonstrating health effects in adult non-smokers began to be reported in the early 1980s[4],[5].

What is environmental tobacco smoke?

The process of smoking a cigarette produces three different types of tobacco smoke. The first is mainstream smoke, the smoke directly inhaled through the burning cigarette by the smoker. Second is exhaled mainstream smoke, the smoke breathed out by the smoker from their lungs. The composition of mainstream and exhaled mainstream smoke is likely to differ, some of the compounds in smoke being retained by the smoker or otherwise altered by the process. Third is sidestream smoke, the smoke which drifts from the end of the lit cigarette. Environmental tobacco smoke (ETS) consists of exhaled mainstream smoke and sidestream smoke.

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[1]. Colley JRT. Respiratory symptoms in children and parental smoking and phlegm production. Br Med J 1974; 2: 201-204.

[2]. Harlap S, Davies AM. Infant admissions to hospital and maternal smoking. Lancet 1974; 1: 529-532.

[3]. Leeder SR, Corkhill RT, Irwig LM, Holland WW. Influence of family factors on the incidence of lower respiratory illness during the first year of life. British Journal of Preventive and Social Medicine 1976; 30: 213-218.

[4]. Hirayama T. Non-smoking wives of heavy smokers have a higher risk of lung cancer: a study from Japan. Br Med J 1981; 282: 183-185.

[5]. Trichopoulos D, Kalandidi A, Sparros L, MacMahon B. Lung cancer and passive smoking. Int J Cancer 1981; 27: 1-4.

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Mainstream and sidestream smoke both contain a large number of chemical carcinogens and other toxic substances, but undiluted sidestream smoke carries many compounds in far greater concentrations. For example, sidestream smoke contains greater amounts of ammonia, benzene, carbon monoxide, nicotine and the carcinogens 2-napthylamine, 4-aminobiphenyl, N-nitrosamine, benz[a]anthracene and benzo-pyrene per milligram of tobacco burned. The particles of sidestream smoke are smaller than those of mainstream smoke, meaning that they can be inhaled more deeply into the lungs[6].

Although it has been estimated that 85% of the smoke present in an average room in which smoking has occurred is composed of sidestream smoke, passive smokers still have a lower exposure to the harmful components of tobacco smoke than the active smoker. Quantification of exposure by the non-smoker is defined by a number of factors including the filtration, tar level and quantity of cigarettes smoked, room size, ventilation rates and duration of exposure[7]. Of course, active smokers are exposed to environmental tobacco smoke as well.

A wealth of scientific evidence now exists showing that the breathing of tobacco-smoke polluted air by non-smokers can lead to serious harm, such as increased bronchitis, pneumonia and other chest illnesses in children, lung cancer and other lung disease, and cardiovascular disease. This is, of course, in addition to the well-known "irritant" effects of tobacco smoke to the eyes, nose, throat and airways passages[6].

The medical evidence about passive smoking has serious ramifications for the continuation of smoking in public places and the workplace, and has been central to a number of court cases in Australia. These issues are discussed in Section 2.

1.1 Major scientific reviews

There have been a number of major reviews of the scientific evidence on the health effects of passive

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6. US Department of Health and Human Services. The Health Consequences of Involuntary Smoking. A report of the Surgeon General. Rockville, Maryland: US Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health, 1986. DHHS Publication No (CDC)87-8398.

7. Fielding JE, Phenow KJ. Health effects of involuntary smoking. New Engl J Med 1988; 319: 1452-1460.

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smoking. Most important are those of the International Agency for Research on Cancer (a branch of the World Health Organisation (1985)[8], Australia's National Health and Medical Research Council (1986)[9], the US Surgeon General (1986) (already reffed), the US National Research Council (1986)[10], the Independent Scientific Committee on Smoking and Health from the United Kingdom (1988)[11], and most recently, the report of the US Environmental Protection Agency (1992)[12]. Key findings from some of these reviews are reproduced below.

National Health and Medical Research Council (Australia, 1986) (ref)

The NH & MRC reached the following conclusions about aspects of passive smoking:

1. Effects on child health

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[8]. International Agency for Research on Cancer. Tobacco Smoking. Lyon: International Agency for Research on Cancer, 1985 (IARC Monographs on the Evaluation of the Carcinogenic Risk of Chemicals to Humans, Volume 38).

[9]. National Health and Medical Research Council. Effects of Passive Smoking on Health. Report of the NH & MRC Working Party on the Effects of Passive Smoking on Health. Adopted at the 101st Session of the Council, June 1986. Canberra: Australian Government Publishing Service, 1987.

[10]. Committee on Passive Smoking. Environmental Tobacco Smoke - Measuring exposures and assessing health effects. Committee on Passive Smoking, Board on Environmental Studies and Toxicology, National Research Council. Washington: National Academy Press, 1986.

[11]. Fourth Report of the Independent Scientific Committee on Smoking and Health. (Chairman: Sir Peter Froggatt). London: HMSO, 1988.

[12]. United States Environmental Protection Agency. Respiratory health effects of passive smoking: Lung cancer and other disorders. Publication EPA/600/6-90/006F. Washington DC: United States Environmental Protection Agency, December 1992.

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Council notes that smoking during pregnancy decreases birth weight and increases perinatal mortality. There is strong evidence to suggest that maternal smoking after birth is associated with increased diseases of the lower respiratory tract in the first year of life.

There is considerable information available which implicates parental smoking as a significant causal factor contributing to middle ear effusions and reduced lung function. Passive smoking may trigger asthma attacks in children who suffer from asthma and may also increase the risk of Sudden Infant Death Syndrome. Children of smoking mothers have a reduced attained height throughout childhood. However, further studies are required to clarify whether these effects, particularly impaired growth and reduced lung function, are due to exposure in utero or to passively inhaled smoke in infancy or to the continued effect of passive smoking through childhood.

2. Adult respiratory effects

Council notes that the epidemiological evidence shows that inhalation of passive smoke by healthy individuals and those with pre-existing respiratory disease commonly causes acute irritant effects in the upper and, to a lesser extent, the lower respiratory tracts. There are sufficient data to indicate that asthmatics may suffer significant acute effects following exposure to passive smoke. However, there is insufficient evidence to assess the effects of passive smoking upon susceptible individuals who have airways hyper-reactivity or atopy but who are not clinically asthmatic.

Council notes that, in several other important areas, there is insufficient scientific evidence yet available. In particular:

(1) the effect on lung function of acute exposure to passive smoke in healthy individuals appears not to be substantial nor is the evidence consistent;

(2) few data are available regarding the effects upon both the upper and lower respiratory tracts of chronic passive smoking in healthy individuals; and

(3) there are no data on the effects of passive smoking during childhood on subsequent lung function in adulthood. Research in these several areas warrants encouragement and support.

3. Cancer

Council notes that there is mounting epidemiological evidence that passive smoking may increase the risk of occurrence of lung cancer. Despite limitations in the amount of data available, and despite research

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difficulties in making satisfactory estimations of individual exposure, a consistent pattern of moderately increased risk of lung cancer in passive smokers has emerged. In view of this pattern, of the known and substantial increase in risk of lung cancer in active smokers (and the lack of a threshold dose), and of the documented levels of bodily assimilation of passively-inhaled smoke, it is therefore prudent public health policy to infer an increased risk of lung cancer from passive smoking.

Council notes that the epidemiological evidence that passive smoking is associated with an increased risk of cancers at sites other than lung is less substantial and less consistent than for lung cancer.

Council also notes that the International Agency for Research on Cancer (a branch of the World Health Organisation) has recently concluded that 'passive smoking gives rise to some risk of cancer'.

4. Cardiovascular Disease

Council notes that, while there is clear epidemiological evidence of markedly increased rates of myocardial infarction, re-infarction, and sudden (cardiac) death in active smokers, there is very limited evidence available about the cardiovascular effects of passive smoking. While two follow-up (cohort) studies of non-smokers have reported moderate increases in the risk of coronary heart disease mortality associated with passive smoking, there is an urgent need for further research into this potentially important public health question. This is particularly so in view of recent research indications of effects of low dosage of tobacco smoke and its constituents upon cardiac haemodynamics, particularly in persons with pre-existing coronary heart disease.

The US Surgeon General: The Health Consequences of Involuntary Smoking, 1986 (REF)

This report reached three major conclusions:

1. Involuntary smoking is a cause of disease, including lung cancer, in healthy non-smokers.

2. The children of parents who smoke compared with the children of non-smoking parents have an increased frequency of respiratory infections, increased respiratory symptoms, and slightly smaller rates of increase in lung function as the lung matures.

3. The simple separation of smokers and non-smokers within the same air space may reduce, but does not eliminate, the exposure of non-smokers to environmental tobacco smoke.

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US Environmental Protection Agency (EPA) Report: Respiratory health effects of passive smoking: Lung cancer and other disorders in children (1992) (already refed).

Major conclusions:

Based on the weight of the available scientific evidence, the US Environmental Protection Agency (EPA) has concluded that the widespread exposure to environmental tobacco smoke (ETS) in the United States presents a serious and substantial public health impact.

In adults:

* ETS is a human lung carcinogen, responsible for approximately 3,000 lung cancer deaths annually in US nonsmokers.

In children:

* ETS exposure is causally associated with an increased risk of lower respiratory tract infections such as bronchitis and pneumonia. This report estimates that 150,000 to 300,000 cases annually in infants and young children up to 18 months of age are attributable to exposure to ETS.

* ETS exposure is causally associated with increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation, and a small but significant reduction in lung function.

* ETS exposure is causally associated with additional epidodes and increased severity of symptoms in children with asthma. This report estimates that 200,000 to 1,000,000 asthmatic children have their condition worsened by exposure to ETS.

* ETS exposure is a risk factor for new cases of asthma in children who have not previously displayed symptoms.

The EPA report classifies ETS as a Group A carcinogen under EPA's carcinogen assessment guidelines. This classification is reserved for those compounds or mixtures which have been shown to cause cancer in humans, based on studies in human populations.

Note: The EPA did not consider evidence concerning ETS and heart disease and other cancers.

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1.2 Cardiovascular disease and passive smoking

Research findings from Australia and overseas have confirmed an association between exposure to

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environmental tobacco smoke and the development of cardiovascular disease[13],[14],[15],[16].

Two reviews of the available epidemiological studies measuring ETS exposure and the incidence of cardiovascular disease have concluded that passive smoking increases the risk of heart disease (Glantz, Steenland). Glantz and Parmley (ref) estimated that heart disease caused by passive smoking is the third leading preventable cause of death in the United States, ranking behind active smoking and alcohol abuse, and that non-smokers living with smokers showed an increased risk of ischaemic heart disease or myocardial infarction of around 30%. A clear dose-response relationship was evident. The authors concluded that it was likely that disease mechanisms were similar in non-smokers to those causing heart disease in active smokers, but that exposure to passive smoking also caused biochemical and enzyme changes, which could promote disease progression in non-smokers (Glantz). (Mechanisms by which active smoking causes heart disease are discussed in Chapter 3, Section 1). Both reviews concluded that passive smoking caused more than ten times the burden of illness through heart disease than it did from lung cancer.

A New South Wales study has shown that exposure to environmental tobacco smoke at home more than doubles the risk of myocardial infarction or coronary death among non-smoking women (Dobson et al). This study has also observed that exposure to ETS increases fibrinogen concentrations in non-smokers. An increased level of fibrinogen, a blood clotting factor, in turn promotes development of thrombosis (blood clotting), which suggests that passive smoking may increase the risk of

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[13]. Beaglehole R. Does passive smoking cause heart disease? [Editorial]. Br Med J 1990; 301: 1343-1344.

[14]. Glantz SA, Parmley WW. Passive smoking and heart disease epidemiology, physiology, and biochemistry. Circulation 1991; 83: 1-12.

[15]. Steenland K. Passive smoking and the risk of heart disease. JAMA 1992; 267: 94-99.

[16]. Dobson A, Alexander HM, Heller RF, Lloyd DM. Passive smoking and the risk of heart attack or coronary death. Med J Aust 1991; 154: 793-797.

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cardiac death by at least some of the same mechanisms as active smoking (same ref).

1.3 Other health effects of passive smoking

The body of research on passive smoking continues to grow. In addition to the health effects described in the conclusions of the major reviews cited above, research evidence has linked passive smoking with the following effects on health:

Asthma

An Australian review of the medical evidence has confirmed that exposure to environmental tobacco smoke contributes to the incidence of childhood asthma. It may do this in the following three ways: by inducing asthma in a genetically predisposed child, by maintaining a state of increased hyper-responsiveness following exposure to an allergen, virus or irritant, and by provoking acute attacks of asthma[17].

Measures of airways responsiveness (that is, the ability of the airways to constrict in response to certain stimuli), provide a useful indicator of the presence of asthma. Australian research has shown that the level of airway responsiveness in early life is increased with a family history of asthma, parental smoking, or both[18].

Parental smoking during pregnancy and risk of cancer in childhood

A number of studies have pointed to an elevated risk of cancer in children of smokers, particularly leukaemia (USSG 1986 103-104). Recent research has suggested that smoking by either parent during pregnancy is associated with a higher incidence of all childhood cancers combined, but especially acute lymphocytic leukaemia and lymphoma. There may be an association between paternal

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[17]. Landau L. Smoking and childhood asthma. Med J Aust 1991; 154: 715-716.

[18]. Young S, Le Souef PN, Geelhoed GC, Stick SM, Turner KJ, Landau LI. The influence of a family history of asthma and parental smoking on airway responsiveness in early infancy. N Engl J Med 1991; 324: 1168-1173.

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smoking and brain cancer[19]. At this stage, these findings should be considered tentative[20].

Cystic fibrosis

Individuals with cystic fibrosis, an inherited condition present from birth, have abnormal secretions, particularly in the lungs and intestine. For this reason, sufferers are prone to recurrent lung infections and malabsorption of food. They are frequently relatively malnourished and, typically, are shorter and lighter than unaffected individuals. They usually have increased food requirements to offset the poor absorption of food. Research has shown that children with cystic fibrosis who are exposed to tobacco smoke in the home are smaller and lighter than those not exposed, suggesting a possible link between passive smoking and growth and appetite[21].

Cancer of the uterine cervix in non-smokers

There is evidence that passive exposure to tobacco smoke, as well as active smoking, is a risk factor for the development of cancer of the cervix[22]. Recent American research has shown that nicotine is present in the cervical fluid of non-smokers following exposure to passive smoking[23]. Nicotine levels were highest among

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19. John EM, Savitz DA, Sandler DP. Prenatal exposure to parents' smoking and childhood cancer. Am J Epidemiol 1991; 133: 123-132.

20. Pershagen G, Ericson A, Otterblad-Olausson P. Maternal smoking in pregnancy: does it increase the risk of childhood cancer? Int J Epidemiol 1992; 21: 1-5.

21. Rubin BK. Exposure of children with cystic fibrosis to environmental tobacco smoke. N Engl J Med 1990; 323: 782-788.

22. Slattery ML, Robison LM, Schuman KL et al. Cigarette smoking and exposure to passive smoke are risk factors for cervical cancer. JAMA 1989; 261: 1593-1598.

23. Jones CJ, Schiffman MH, Kurman R, Jacob P, Benowitz NL. Elevated nicotine levels in cervical lavages from passive smokers. AJPH 1991; 81:378-379.

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those women exposed to ETS within the home, and active smokers had higher levels still. The authors conclude that even low-level exposure to environmental tobacco smoke may result in systemic effects.

Snoring and night cough in children

Children exposed to tobacco smoke are more likely to be snorers and cough during the night, probably due to a chronic effect of smoke on the upper airways[24],[25].

Effects of parental smoking, and maternal exposure to passive smoking, on the unborn child

See Chapter 3, Section 7 for discussion.

1.4 Exposure of Australian children to passive smoking in the home

Given the particular vulnerability of infants and young children to the health effects of passive smoking as described in the preceeding sections, it is of concern that many children are exposed to passive smoking in the home environment. Table 1.1 below shows that 570,000 Australian children aged four years or less live in households with one or more smokers[26]. This represents 46% of all children in this age range.

Table 1.1: Household exposure to tobacco smoke in children aged 4 years or less, Australia 1989 - 1990

Number of children ('000)

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[24]. Corbo GM, Fuciarelli F, Foresi A, De Benedetto F. Snoring in children: association with respiratory symptoms and passive smoking. Br Med J 1989: 299: 1491-4.

[25]. Forastiere F, Corbo GM, Michelozzi P et al. Effects of environment and passive smoking on the respiratory health of children. Int J Epidemiol 1992; 21: 66-73.

[26]. Australian Bureau of Statistics. National Health Survey 1989 - 1990. **WHAT IS THE CATALOGUE NUMBER/FULL REF FOR THIS?**

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Number of dependent children in household	Nil smokers	1 - 2 smokers	3 or more smokers	Total
0	5.1	7.1	0.9	13.1
1 - 2	435.5	366.1	13.3	813.7
3 or more	231.4	175.3	5.0	411.9
Total	673.2	550.7	19.2	1,243.1

Source: Australian Bureau of Statistics (ref)

1.5 Estimations of deaths attributable to passive smoking

Lung cancer

Different studies have attributed varying risks to the non-smoker of developing lung cancer due to passive smoking, depending on how the researchers have classified levels of exposure. The National Research Council in the United States has reviewed and evaluated those studies which allow cross comparisons, and have put the "best estimate" of relative risk for non-smokers developing lung cancer due to passive smoking at 1.42 (meaning that exposed non-smokers have a 42% higher risk of getting lung cancer than non-exposed non-smokers)[27].

From a 1986 review of the available epidemiological studies of lung cancer and passive smoking, researchers have concluded that about one third of lung cancer cases in non-smokers who live with smokers, and about a quarter of the cases in non-smokers in general, may be attributed to exposure to environmental tobacco smoke[28].

Two recent studies estimate that about 140 deaths from lung cancer annually may be attributed to passive smoking in Australia. Using mortality data from the United States, it has been calculated that in 1983, 136

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[27]. National Research Council Committee on Passive Smoking. Environmental tobacco smoke: Measuring exposures and assessing health effects. Board on Environmental Studies and Toxicology, National Research Council. Washington DC: National Academy Press, 1986: 241-242.

[28]. Wald, Nanchahal K, Thompson SG, Cuckle HS. Does breathing other people's tobacco smoke cause lung cancer? Br Med J 1986; 296: 1217-1222.

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Australian deaths from lung cancer could be attributed to passive smoking[29].

Of these, approximately 60 deaths were among non-smokers and 76 among current or ex-smokers.

The report concluded with the following comment:

> This total of 136 deaths is quite small. The deaths are, however, preventable. In addition, they do not appear to be quite so few when compared with the 56 deaths attributed to the personal use of opiates in 1980 and the estimated total of 281 deaths from mesothelioma and lung cancer caused annually by all forms of exposure to asbestos in Australia. It seems appropriate that public health action should now be turned to passive smoking.

A more recent estimate has placed the number of deaths due to lung cancer arising from passive smoking at 146 deaths in 1986[30].

Environmental tobacco smoke is a major cause of cancer compared to other environmental health risks. It has been estimated that non-smokers have a 25% higher risk of developing cancer from exposure to ETS than from indoor radon, and that this risk is about 57 times greater than the combined estimated cancer risk from all the hazardous outdoor air pollutants currently regulated by the US Environmental Protection Agency: airborne radionuclides, asbestos, arsenic, benzene, coke oven emissions, and vinyl chloride[31]. British researchers Peto and Doll have expressed the risk of developing lung cancer from passive smoking as being about ninety times higher than the risk of developing an asbestos-related cancer due to asbestos in buildings[32].

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29. Armstrong BK. Commentary: Passive smoking and lung cancer. Community Health Stud 1987; 11(supple): 6s-8s.

30. Holman CDJ, Armstrong BK, Arias LN et al. The quantification of drug caused morbidity and mortality in Australia. Canberra: Commonwealth Department of Community Services and Health, 1988.

31. Repace JL, Lowrey AH. Risk assessment methodologies for passive smoking-induced lung cancer. Risk Analysis 1990; 10): 27-37.

32. Peto J, Doll R. Asbestos - Effects on health of exposure to asbestos. Health and Safety Commission. London: HMSO, 1985.

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Cardiovascular disease

An American review of the epidemiological evidence linking passive smoking with cardiovascular disease has estimated that passive smoking causes around ten times as many deaths from heart disease as it does from lung cancer (ref Glantz). Extrapolated to Australia, using the mortality estimates from lung cancer discussed above, an estimated 1,400 Australians die annually from cardiovascular disease due to passive smoking.

1.6 Public opinion about passive smoking

Surveys on beliefs about the health risks of passive smoking were commissioned by the Anti-Cancer Council of Victoria in Victoria in 1985[33], 1989[34] and 1991[35], and the New South Wales Cancer Council in 1990[36](Table 1.2). The results show that a majority of smokers, as well as non-smokers, believe that passive smoking is harmful to health, and that this awareness has increased over time.

Table 1.2: Public opinion about passive smoking

Those agreeing that the health of non-smokers can be damaged by other people's tobacco smoke:

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[33]. Hill DJ. Public opinion in Victoria about the dangers of passive smoking. Med J Aust 1986; 144: 615-616.

[34]. Borland R, Naccarella L. Public opinion about regulation of smoking to protect others. In: Victorian Smoking and Health Program. Quit evaluation studies No 5, 1989. Melbourne: Victorian Smoking and Health Program, 1991: 147-151.

[35]. Mullins R, Borland R, Hill D. Smoking knowledge, attitudes and behaviour in Victoria: Results from the 1990 and 1991 Household Surveys. In: Victorian Smoking and Health Program. Quit evaluation studies No 6, 1990 - 1991. Melbourne: Victorian Smoking and Health Program, 1992: 1-30.

[36]. New South Wales Cancer Council Public Opinion Survey. Smoking in restaurants. Sydney: New South Wales Cancer Council, July 1990.

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	1985 (Victoria)	1989 (Victoria)	1990 (NSW)	1991* (Victoria)
All respondents	73%	83%	84%	86%
Non-smokers	80%	89%	90%	-
Current smokers	57%	67%	69%	73%
Never-smokers	-	-	-	92%
Past smokers	-	-	-	87%

Sources: Hill (Public opinion..), Borland and Naccarella (ref), New South Wales Cancer Council (ref), Mullins, Borland and Hill (ref).

* Note: The 1991 survey undertaken in Victoria distinguishes between those non-smokers who have never smoked ("never-smokers") and those who are former smokers ("past-smokers"). The non-smoker classification for previous years covers both subgroups.

References to Chapter 1

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2. SMOKING IN THE WORKPLACE AND IN PUBLIC PLACES

2.1 Background

Smoking has long been restricted in certain settings, mainly due to considerations of hygiene and safety. But the advent of evidence which unequivocally states that passive smoking harms the health of non-smokers (see Chapter 4), has brought the issue of smoking in the workplace and in public places into sharp focus. In June 1986 the National Health and Medical Research Council (NH & MRC) adopted the following recommendations made by the NH & MRC Working Party on the Effects of Passive Smoking on Health[1]:

> Council recommends that, in view of the evidence that passive smoking increases the risks of at least some diseases of childhood and adulthood, particularly disorders and diseases of the respiratory system, the following policies should be considered by health authorities in Australia as means of protecting the health of non-smokers:
>
> 1. Development of procedures, regulations, or laws facilitating or requiring the restriction or prohibition of smoking:
>
> a. Within the work environment. The available evidence indicates that exposure to passive smoking is, on average, substantially higher at work than at home. An atmosphere free of tobacco smoke should be regarded as the workplace norm. Employers should be reminded of obligations to provide a safe working environment.
>
> b. In enclosed public spaces, hospitals, restaurants and transport.
>
> In recommending this policy, Council notes the apparently successful approach in some US States of declaring smoking to be prohibited in all public places and work places unless specifically permitted.
>
> 2. Explicit inclusion in smoking-related health education material of information about the known or suspected effects of passive

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[1]. National Health and Medical Research Council. Effects of passive smoking on health. Report of the NH & MRC Working Party on the Effects of Passive Smoking on Health. Adopted at the 101st session of the Council, June 1986. Canberra: Australian Government Publishing Service, 1987.

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smoking upon health. This material should assist decisions in the home (including decisions about ventilation) as well as in the workplace and in public places.

In making these recommendations, Council acknowledges that further research is necessary to confirm and elaborate these effects of passive smoking upon health. However, mindful of the delays involved, historically, in both accepting and acting upon the evidence of the serious health consequences of active smoking, Council considers that there is now sufficient evidence pertaining to the effects of passive smoking to require prudent public health action of the kind recommended above.

Since drawing these conclusions, the views of the NH & MRC have been confirmed by a number of other major international reports (see Chapter 4). Mainstream medical and scientific experts have sufficient confidence in the scientific evidence to be to be prepared to testify in court about the health effects of passive smoking. Also clear is the legal obligation of the employer to provide a safe working environment free of foreseeable and avoidable risks to health and safety for employees and others who may enter it. This obligation is enshrined in the state and territory Occupational Health and Safety Acts; and affirmation that the provisions of these acts apply to the health dangers of environmental tobacco smoke has been explicitly stated in Federal Parliament on at least two occasions. A number of worker's compensation cases concerning passive smoking have been settled in and out of courts in Australia and overseas[2],[3],[4]. The confirmation by a Federal Court ruling in early 1991 that environmental tobacco smoke was a cause of disease, has effectively formed a precedent on the issue (see Section 3 below). The point was reinforced with the decision in the case of Mrs Liesel

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[2]. Ramstrom LM. A case of lung cancer classified as occupational injury due to passive smoking at the workplace - a ruling of the Swedish Insurance Court of Appeal. Stockholm: National Smoking and Health Association, 1986.

[3]. Clement B, Hall C. Passive smoking victory may lead to cigarette ban. The Independent [London] 1993 January 28: 1.

[4]. Woodward SD, Winstanley MH. Lung cancer and passive smoking at work: the Carroll case. Med J Aust 1990; 153: 682-684.

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Scholem in mid-1992 (see Section 4 below), and the declaration by the US Environment Protection Agency in December 1992 that environmental tobacco smoke is a Group A carcinogen (shown to cause cancer in humans)[5](see also Chapter 4, Section 1). In early 1993 legislation was proposed in New South Wales to ban smoking in enclosed work places, and in the Australian Capital Territory to ban smoking in public places.

Many government and private bodies have introduced total or partial bans on smoking in the workplace and other public places (see Sections 6, 11 and 12 below). Workplace smoking bans have generally received strong support among public and private sector workers, and the unions. Despite the best efforts of the tobacco industry to deflect debate and trivialise the issue, there is no doubt that they have lost the battle scientifically, legally, and in the public arena.

2.2 Legal obligation to provide a safe workplace

Each Australian state and territory has its own occupational health and safety act. Although their wording varies slightly, they nonetheless effectively state that:

1. the employer has a duty to provide a safe workplace for employees and others who may enter the workplace, such as clients, visitors, or independent contractors.

2. employees have the obligation not to expose fellow employees or others who may enter the worksite to hazardous situations. They are also obliged to co-operate with employers over safety matters.

It could be argued that the various state and territory acts provide a legal obligation for owners of places used by the public (for example, restaurants) to provide a smoke-free environment, on the grounds that they owe both their employees (for example waiters and attendants) and their customers and clients a duty of care to provide a safe environment (see also Section 11 below).

The legal position concerning passive smoking has also been outlined in Federal Parliament. In November 1986, the Federal Attorney General provided advice which was tabled in the House of Representatives:

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5. United States Environmental Protection Agency. Respiratory health effects of passive smoking: Lung cancer and other disorders. Publication EPA/600/6-90/006F. Washington DC: United States Environmental Protection Agency, December 1992.

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> An employer has a common law duty of care to take all reasonable steps to protect its employees' health and safety, including the provision and maintenance of safe workplaces.
>
> The Attorney-General's Department advised ... that injury from passive smoking is reasonably foreseeable and that consequently such an injury could give rise to an action for damages at common law[6].

This position was restated in June 1991, in the wake of the Morling decision (see Section 3 below). Senator the Honorable Kerry Sibraa, President of the Senate, tabled advice from the Joint House Department which stated that in light of the Federal Court (Morling) decision, "the onus now appears to fall on employers and managers of facilities to take a more positive role in protecting non-smokers."[7] Senator Sibraa commented that:

> In summary, a failure to limit employee exposure to smoke could be a breach of an employer's duty to "take all reasonably practicable steps to protect the health and safety at work of the employer's employees". (Hansard)

2.3 The Australian Federation of Consumer Organisations Inc v Tobacco Institute of Australia Ltd: the Morling judgement

Note: Except where otherwise indicated, the major reference for this section is Everingham and Woodward[8], which provides full transcripts of the judgement as well as commentary.

On 7 February 1991, Justice Morling of the Federal Court of Australia handed down the findings on the lengthy court case between the Australian Federation of Consumer Organisations (AFCO) and the Tobacco Institute of Australia. Justice Morling found that the Tobacco

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[6]. House of Representatives, Hansard. 1986 November 13: 2979. Advice from the Attorney General.

[7]. Senate, Hansard. 1991 June 3: 4089-4094.

[8]. Everingham R, Woodward S (eds). Tobacco litigation. The case against passive smoking. AFCO v TIA. An historic Australian judgement. Sydney: Legal Books, 1991.

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Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

Institute of Australia, in publishing a particular advertisement stating its views on passive smoking, had engaged in misleading or deceptive conduct in contravention of section 52 of the Trade Practices Act 1974. The Court duly issued an injunction restraining the Tobacco Institute of Australia from republishing the offending advertisement, or publicly restating its sentiments. Justice Morling's decision is the first authority of an Australian Superior Court dealing directly with the health effects of passive smoking. (In October 1990 the District Court of the Hague issued an interim judgement that the Dutch Foundation on Smoking and Health ("Stivoro") was justified in publishing its view that passive smoking is damaging to health, after which the tobacco dropped their lawsuit[9]).

Background to the case

During 1986 the Tobacco Institute of Australia, the lobbying organisation representing the interests of the tobacco companies operational in Australia, lodged a series of advertisements in major daily newspapers. The theme of the advertisements was passive smoking, and the advertisements sought in various ways to persuade the public that passive smoking was not a health problem.

One of these advertisements, lodged in 14 newspapers on 1 July 1986, claimed among other things, that "there is little evidence and nothing which proves scientifically that cigarette smoking causes disease in non-smokers." The advertisement argued that while tobacco smoke could be an annoyance, it posed no health risks, and in support of its contention used the names of three major health agencies - the World Health Organisation, the Institute of Cancer Research in the UK, and the American Cancer Society. The advertisement also claimed that a particular article entitled "Relationship of passive smoking to risk of cancer and other smoking-associated diseases" by Lee, Chamberlain and Alderson, supported the Institute view and was based on research involving a sample of 12,000.

Dr Paul Magnus of the National Heart Foundation of Australia wrote to Lee, Chamberlain and Alderson and asked whether the referenced 12,000 people was accurate. On behalf of his co-authors, PN Lee, a known tobacco

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9. Dutch Foundation on Smoking and Health (Stivoro). Tobacco industry withdraws from lawsuit against Stivoro [Media release]. Dutch Foundation on Smoking and Health, 1991 July 31.

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

industry consultant, replied "No", and said for common understanding the research involved "about 700"[10].

Each of the three organisations mentioned in the advertisement responded promptly with strong denials of their support for the Tobacco Institute's view, and accusations of distortion and misrepresentation of their opinions on the health effects of passive smoking. The Institute's use of the article by Lee et al was also criticised, in that the article's conclusions about passive smoking were based on a sample of around 700 people, not 12,000.

The Australian Council on Smoking and Health (ACOSH) formally objected to the Advertising Standards Council (ASC) about the misleading nature of the advertisement, but although the ASC upheld ACOSH's complaint, it is not empowered to take punitive action other than to request that an advertisement be withdrawn, or disallowed from future publication by its member organisations.

The peak policy body for the consumer movement, the Australian Federation of Consumer Organisations (AFCO) took a different approach, by instituting proceedings under the Trade Practices Act. This Act (among other things) prohibits misleading and deceptive advertising. Their first attempt brought about a ruling by the Trade Practices Commission (the body empowered with administering the Act) that the Act had been breached, that the Tobacco Institute should not republish the offending advertisement, and should publish corrective copy. However AFCO sought stronger guarantees that future statements by the Tobacco Institute of Australia on passive smoking would not intend to mislead in the same way, and so instituted proceedings in the Federal Court of Australia to seek an injunction against the Institute in July, 1987. The proceedings began in earnest on 20 November 1988.

The hearing lasted for ninety days, and included a period of sitting in the United Kingdom to facilitate the presentation of evidence by overseas expert witnesses. Witnesses for AFCO were expert in epidemiology, paediatrics, toxicology and respiratory medicine. They were Australian Professors Lou Landau, Tony McMichael, Peter Phelan and Bernard Stewart, and Drs Bruce Armstrong, Tony Breslin, Peter Le Souef, and Terry Nolan. Overseas expert witnesses were Sir Richard Doll and Professors Nick Wald (Britain), Dwight Janerich and Dimitrios Tricholpoulos (USA).

The Tobacco Institute called statistical consultants, physicians and toxicologists from Australia, the United

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[10]. **CORRESPONDENCE BETWEEN PN LEE AND FPM**

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

States, Britain and Sweden. It was noted by Justice Morling that the Institute did not number any epidemiologists or specialist paediatricians among its witnesses. Justice Morling interpreted this lack as a significant deficiency in its evidence, and found reason to criticise the testimony of a number of Institute witnesses on the grounds of evasiveness, unreasonable expectations of scientific proof of causality or hypercriticism of existing research. For one witness, a consulting statistician, 80% of the income of his practice consisted of work undertaken for tobacco companies.

Proceedings concluded on 25 September 1990, and Justice Morling handed down his 211 page decision in February of the following year. Legal costs for the Tobacco Institute were estimated to be about $7 million. AFCO received some legal aid to assist with the financing of its case, which cost in total $1.3 million, but also enjoyed the goodwill of its legal representation and expert witnesses, all of whom deferred payment of their costs, and of ASH and Australian heart and cancer organisations, which contributed by providing advice, research materials and other support services (BMJ chapbrain and wood 1st article).

Key findings

Justice Morling found that the Tobacco Institute of Australia was misleading in its statement that "there is little evidence and nothing that proves scientifically that passive smoking is harmful to health".

Instead, he concluded that "there is compelling scientific evidence that cigarette smoke causes lung cancer in non-smokers"; that there is "overwhelming evidence... that passive smoking causes some people to experience attacks of asthma;" and that there was "No rational basis... for the holding of an opinion that there is little evidence and nothing which proves scientifically that cigarette smoke causes attacks of asthma."

Justice Morling found the evidence concerning the health effects of passive smoking for young children particularly compelling:

> In my opinion the only conclusion open on the evidence is that the statement that there was little evidence and nothing which proves scientifically that cigarette smoke causes disease in non-smokers was demonstrably false in 1986 in so far as it applied to respiratory disease in children in the first year of life. The statement remains false to this day. In my view the falsity of the statement is demonstrated whatever meaning one gives to the terms "little evidence" and "scientific proof". I

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share the opinion expressed by Professor Phelan that the evidence establishing a causal relationship between passive smoking and respiratory disease in very young children is overwhelming. The evidence is of such strength that it constitutes scientific proof."

In his summing up, Justice Morling stated:

"... there is strong public interest in the respondent being prevented from making the statement that there is little evidence and nothing which proves that cigarette smoke causes disease in non-smokers. Active smokers are likely to be misled or deceived by the statement into believing that their smoking does not prejudice the health of non-smokers, particularly small children. Non-smokers are likely to be deceived or misled by the statement into believing that cigarette smoke does not affect their own health or the health of their children. These are serious matters."

The Court ordered the Tobacco Institute of Australia that:

1. The respondent its servants and agents be restrained from publishing or causing to be published, in trade or commerce, the advertisement [A message from those who do ... to those who don't].

2. The respondent its servants and agents be restrained from making statements in trade or commerce that it is the fact that:

   (a) there is little evidence and nothing which proves scientifically that cigarette smoke causes disease in non-smokers;

   (b) there is little evidence that cigarette smoke causes lung cancer in non-smokers;

   (c) there is nothing which proves scientifically that cigarette smoke causes lung cancer in non-smokers;

   (d) there is little evidence that cigarette smoke causes respiratory disease in children under the age of one year;

   (e) there is nothing which proves scientifically that cigarette smoke causes respiratory disease in children under the age of one year;

   (f) there is little evidence that cigarette smoke causes attacks of asthma in non-smokers;

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(g) there is nothing which proves scientifically that cigarette smoke causes attacks of asthma in non-smokers;

h) there is little evidence that cigarette smoke causes otitis media in children.

3. The respondent its servants and agents be restrained from making statements in trade or commerce that the conclusions drawn in the article "Relationship of passive smoking to risk of cancer and other smoking-associated diseases" by Lee, Chamberlain and Alderson were based on statistical detail in a study involving 12,000 people.

Ramifications

Justice Morling's findings, along with the well-established duty of care of the employer to provide a safe workplace, provide a compelling legal underpinning to the importance of providing a smokefree environment. Following the judgement, state cancer councils around Australia reported a massive increase in enquiries about potential action against employers who had not yet introduced a smoke-free workplace policy[11]. It is likely that many companies will elect to introduce a policy rather than run the risk of workers' compensation cases or civil action[12].

The Australian Employment Law Guide's Workplace Update[13] has drawn the following list of implications for employers from the Morling decision:

* A link between passive smoking and disease among non-smokers has now been established in a court of law.

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[11]. Chapman S, Woodward S. Australian court rules that passive smoking causes lung cancer, asthma attacks, and respiratory disease. Br Med J 1991; 302: 943-945.

[12]. Laurence M. Smoking may be a business hazard. Australian Business 1991 May 1: 44-47.

[13]. Anonymous. Employers' right to ban smoking at work. CCH Australian Employment Law Guide Workplace Update. 1991; 64: 1-2.

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

* Individuals may seek court injunctions against the allowance of smoking in public places. This could conceivably include a workplace.

* A person suffering an illness or disease which can be caused by passive smoking can now, if able to prove that he or she was exposed to cigarette smoke, point to this decision as a legal presumption that the illness/disease was possibly caused by passive smoking.

* Overall, the decision will make it easier for an employee to mount a case against an employer, and harder for the employer to defend it. Prior to this decision, all cases involving workplace passive smoking in Australia have been settled out of court. Note, however, that this decision involved the narrower context of claims made in an advertisement, and an employer defending a passive smoking claim could be expected to seek to have the decision interpreted as narrowly as possible.

* The decision can be expected to encourage the more widespread operation of smoke-free work environment policies, in an attempt by employers to avoid future claims from affected employees.

* Equal opportunity or anti-discrimination legislation has no application to the question of smoking at work. Employers, however, should be aware that the introduction of a non-smoking policy at work should comply with the principles of "industrial fairness". In other words, the policy should not make exceptions based on rank or status.

The Tobacco Institute of Australia's appeal

The TIA is appealing against the Morling decision, on the grounds that the action against it was inappropriately heard under the Trade Practices Act, and on the further grounds of freedom of speech. **SDW RE-WRITING THIS PART.**

2.4 Compensation cases

There have been a number of cases in Australia in which complainants have received compensation for discomfort or disease caused by environmental tobacco smoke. The complainants have variously attributed irritation of the eyes, nose and throat, allergy, headache, nausea, decreased lung function, chronic airways disorders and lung cancer to passive smoking.

Most of these cases have ultimately been settled out-of-court. This generally occurs because the insurance companies underwriting the employers' legal costs prefer to avoid a verdict or judgement against

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them, and allows them rather than the court to nominate an amount for compensation. From this, one can assume that the insurance companies believe that they have little chance of winning a soundly-based case. **TOBACCO IND WATERLOO - AMEND IN RELATION TO.**

The largest compensation payouts which have been disclosed to date are the $65,000 paid out-of-court in July, 1988 by the Melbourne Metropolitan Transit Authority to Mr Sean Carroll, a bus driver who developed lung cancer after 36 years' passive exposure to tobacco smoke (Wood/Win the carroll case), and the $85,000 awarded to Mrs Liesel Scholem in May 1992. Mrs Scholem was awarded damages by the NSW Department of Health in a case heard before the NSW District Court. This is the first Australian passive smoking case to be decided in a full court hearing[14], and publicity following the decision resulted in many major workplaces, and Australian airports, announcing that they would become smokefree[15]. In Western Australia, action is currently being taken by the WA government against the owners of a Perth casino, for failing to provide a smokefree workplace for their employees. The prosecution is taking place under the Occupational Health, Safety and Welfare Act, and was precipitated by a petition to the government by a number of the casino's employees. This case is believed to be the first of its kind in Australia[16].

The following summary lists a number of compensation cases which have been heard in Australia.

Cases arising from illness in non-smokers caused by exposure to environmental tobacco smoke in the workplace:

ANGELA BLECHYNDEN v COMMONWEALTH GOVERNMENT (Western Australia)

Claim: Sinusitis.
Amount of Compensation: Undisclosed (1982).

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[14]. Bagwell S. Aust lights up world's anti-smoking troops. Financial Review 1992 July 20: 12.

[15]. Anonymous. Passive smoker wins test case. The Clean Air Clarion 1992 April - June: 1, 4.

[16]. Ragg M. Australia: Passive smoking prosecution. Lancet 1991; 341: 167.

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

ROY BISHOP v THE COMMONWEALTH OF AUSTRALIA

Reference: Administrative Appeals Tribunal, A 84/109, 14 October 1985.
Claim: Allergy and nausea from exposure to smoke.
Amount of Compensation: $16,000

KEN BISHOP v THE COMMONWEALTH OF AUSTRALIA (Department of Defence)

Reference: Commonwealth Employees Redeployment and Retirement Appeals Tribunal. Administrative Appeals Tribunal, 25 March 1986, A85/100.
Claim: Allergic reaction to smoke.
Amount of Compensation: Undisclosed.

Note: Ken Bishop is no relation to Roy Bishop.

JOHN BURCHMORE v QUEEN ELIZABETH HOSPITAL (SOUTH AUSTRALIA)

Listed for hearing in the South Australian Local Court, April 1986.
Claim: Lung damage.
Amount of Compensation: Settled out of court.
Disclosure of conditions of the settlement are confidential, but believed to be a minimum of $8,000.

BRIAN ROLAND v TELECOM AUSTRALIA

Claim: Severe respiratory complaints.
Amount of Compensation: Undisclosed.

JOY HART v ANSETT AIRLINES OF AUSTRALIA

Reference: Compensation Court of New South Wales, 23 September 1986.
Claim: Nausea, headache, adverse respiratory symptoms.
Amount of Compensation: $20,000.

VICTORIAN SECONDARY SCHOOL TEACHERS' ASSOCIATION v MINISTRY OF EDUCATION

Reference: Workcare Claim, January 1987.
Claim: Severe aggravation of sinuses and acute infection to passages of the nose, throat and facial bones.
Amount of Compensation: Undisclosed.

UNNAMED v SA TAB

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Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

WorkCover claim, compensation not known[17].

UNNAMED v ADELAIDE CASINO

An Adelaide Casino employee has apparently been on WorkCover payments since June 1988, due to illness caused by passive smoking at work (Molloy/Rutter).

ALAN O'BRIEN V MUREE GOLF CLUB (NEW SOUTH WALES)

Reference: Workers Compensation Claim, June 1987, Compensation Court of NSW.
Claim: Emphysema.
Amount of Compensation: $36,500 (Out-of-court settlement).

SEAN CARROLL v MELBOURNE METROPOLITAN TRANSIT AUTHORITY

Reference: Workcare Claim, July 1988, Victorian Accident Compensation Tribunal.
Claim: Lung cancer.
Amount of Compensation: $65,000 (Out-of-court settlement).

LIESEL SCHOLEM v NSW HEALTH DEPARTMENT

Reference: NSW District Court, Sydney, May 27, 1992.
Claim: Exacerbation of asthma symptoms, emphysema.
Common law settlement: $85,000

PHILIP VOSS V VICTORIAN GOVT

Reference: Workcare Claim, August 1991.
Claim: Throat cancer
Amount of compensation: Unknown

Contribution of passive smoking in the workplace to development of disease in an active smoker

GEORGE O'KEEFE V 7 HOTEL EMPLOYERS

George O'Keefe died in March 1987 at the age of 64, having worked as a barman in many Victorian hotels for around 28 years. He developed lung cancer in 1984. A light smoker himself, it was argued that his heavy

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17. Molloy B, Rutter R. Smoker clamps tighten. The Adelaide News 1991 April 24: 3.

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

exposure to smoke in the workplace had contributed to his development of cancer.

Reference: Workcare Claim, June 1991.
Claim: Lung cancer
Amount of compensation: $20,000 (Out-of-court settlement)

Tobacco company employees encouraged to smoke "in the line of duty"

There are at least two cases which have been launched against tobacco companies by employees or former employees who allege that the companies actively encouraged them to smoke as part of their work practices, and who subsequently developed a tobacco-related disease.

THOMAS DUNNE V ROTHMANS OF PALL MALL (AUSTRALIA) LTD

Thomas Dunne was a travelling salesman for Rothmans in South Australia between 1975 and 1984. He smoked for twenty years, his consumption going from 5 cigarettes a day when he commenced work with Rothmans to 80 cigarettes a day. He was diagnosed as having heart disease, and was subsequently retired by the company. The case was heard before the Workers' Compensation Court in October 1986 but settled out-of-court for an undisclosed sum[18].

BRIAN LEES V ROTHMANS OF PALL MALL (AUSTRALIA) LTD AND RJ REYNOLDS LTD

Brian Lees became a smoker when he began working for RJ Reynolds in 1973, apparently advised that it "would be in his best interests" to do so. Between 1981 and 1987 he worked for Rothmans. Mr Lees had major heart surgery in June 1987, and subsequently made a claim against the two tobacco companies in the South Australian Industrial court. Mr Lees received an out-of-court settlement said to be around $20,000 in May, 1990[19].

Protection of young children from environmental tobacco smoke in the home

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[18]. Anonymous. Salesman's job up in smoke because of heart ailments. The Adelaide Advertiser 1986 October 6.

[19]. Anonymous. Tobacco payout "not a precedent". The Adelaide Advertiser 1990 May 5: 4.

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

There have been at least two court cases heard in the United States of America in which the court has ordered that a smoking parent should not smoke in proximity to a child susceptible to respiratory problems. The cases have been associated with custodial issues as a part of divorce proceedings[20]. These developments are extreme and isolated and one would hope that similar cases do not come to pass in Australia[21], although it has been suggested that similar orders could be made under existing provisions of the Family Law Act 1975 (Watt).

2.5 Introducing a policy on smoking in the workplace

Note: The following list of steps to take in introducing a policy in the workplace is summarised from the National Heart Foundation of Australia's guide "Going Smokefree"[22]. Readers interested in pursuing this issue in greater detail are referred to this publication, as well as the Further Reading List in Appendix VI. Organisations listed in Appendix I are also able to provide advice.

Companies and organisations of all types and sizes are introducing a smoke-free working environment. In organisations where there is little disagreement about introducing a policy, the change may be made simply; other organisations may need to devise more complex policies and introduce changes gradually. Introducing a policy generally requires moving through the following stages:

1. Take the right approach: be positive. Remember that the issue is not whether people smoke, but where they smoke. The aim of the policy is to achieve a workplace with clean air, of which smoking is one component.

2. Be informed: research the issue. Understand the health, legal and economic aspects of smoking in the

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[20]. Watt M. Family Law Notes. Protection from passive smoking: legal gas-masks appear on US market. Australian Law News 1992 October: 53.

[21]. Chapman S. Smoking and statistical overkill [Letter]. Lancet 1993; 341: 58-59.

[22]. National Heart Foundation of Australia. Going Smokefree. A guide for workplaces. Canberra: National Heart Foundation of Australia (undated).

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

workplace, and wider issues related to smoking in the workplace.

3. Gain the support of decision-makers: get management commitment. This might include briefing on occupational health and safety issues, as well as other aspects of smoking in the workplace from step 2.

4. Get representation: form a working party. This group should comprise representation from all major groups in the organisation. The role of the working party is to prepare policy, including a strategy for implementation, staff consultation and education. The working party continues to monitor the policy and its implementation.

5. Increase awareness of the issue: inform the workforce. All levels of the organisation need to be briefed about the reasons for introduction of the policy and the process of policy development.

6. Assess the current situation: consult and collect information. Then an appropriate policy can be developed. Note: consultation does not mean debating whether a policy is going to be introduced. This is non-negotiable, on health and safety grounds.

7. Design the policy: the type (ideally totally smoke-free), the phase-in period, the education and consultation process, provision for support and assistance for smokers, and outlining of procedures for non-compliance.

8. Write the policy, including rationale, timeline, specific smoking restrictions during the phase-in period, assistance to smokers, and procedures for non-compliance. Other considerations might include: sale of cigarettes (from a canteen or vending machine), mention of the policy in job advertisements, signposting of smoking restrictions in public access areas, and co-operation with other workplaces which share premises.

9. Announce the policy, taking into account the best timing for your organisation. It may also be appropriate to seek some publicity for the change.

10. Educate and provide information, using a variety of strategies to suit different groups within the organisation.

11. Support and assist smokers. This includes allowing phase-in periods and adjustment breaks, providing contact people to discuss problems with and advice on coping without cigarettes, quit information and

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access to quit courses if desired, and incentives for those who want to quit.

12. Ensure compliance. While every effort should be made to assist the employee in understanding and complying with the policy, smoking policy should not be regarded as being different from any other occupational health and safety policy.

13. Monitor, review and evaluate the policy. Feedback from within the organisation will help in gauging problem areas. Changes may be needed, but should not compromise the goal of protecting non-smokers from tobacco smoke.

The benefits of introducing a policy may be summarised as follows[23] :

For employers:

* Reduced risk of litigation/compensation costs by preventing staff from developing passive smoking caused illness
* Reduced absenteeism from smoking and passive smoking-caused illness
* Increased productivity
* Reduced cleaning and maintenance costs (carpets, furnishings, machinery affected by smoke)
* Healthy, progressive image
* Reduced fire risk
* Possibly reduced insurance costs

For employees:

* Healthier, cleaner and safer working environment
* Reduction/removal of tension between smokers and non-smokers
* Raised awareness of health risks of smoking
* Possible assistance for smokers to quit

2.6 Trends in policy adoption in Australian workplaces

There are many examples of major public and private sector organisations which have introduced a policy on smoking in the workplace. The Commonwealth Department of Health became smoke-free on 1 December 1986 and all Commonwealth public service departments became smoke-free by March 1988. Telecom, Australia Post, Shell, ICI,

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[23]. Commonwealth Department of Health. Guidelines for implementation of the smoke-free working environment policy within the Commonwealth Department of Health on 1 December 1986. Canberra: Commonwealth Department of Health, 1986.

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

CSIRO, BHP[24], AMP, Westpac, 3M, Price Waterhouse and IBM (Laurence article) are a few of the many organisations which have adopted policies, along with most hospitals and state health departments. Victorian TAB betting offices became smoke-free on 1 January 1992[25]. The Australian Army has also restricted smoking in all offices, halls and mess facilities[26].

Recent surveys in Victoria and New South Wales show that the majority of top private companies in these states have introduced either partial or complete smoke-free policies. In Victoria in 1992, 94% of the top 139 companies surveyed had either total or partial smoke-free policies[27], up 9% from the previous year[28]. In New South Wales in 1991, 73% of the 232 companies surveyed had introduced smoke-free workplaces, an increase of almost 20% from survey results in the previous year[29]. The proportion of companies with total (rather than partial) bans had also increased. A survey of small businesses in New South Wales in 1992 has shown that 75% have some degree of workplace smoking ban (NSW NHF ref). All of

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[24]. Mangan J. Pity the poor sidestreamers. Rydges 1987 September: 32.

[25]. Anonymous. Smoking off-limits at TAB. Herald-Sun 1991 February 6: 11.

[26]. Newsome B. Diggers butt out at work. Herald-Sun 1991 December 9: 3.

[27]. Mullins R. Smoking restrictions in some of Australia's main companies based in Victoria: an update. Prepared for Quit by the Centre for Behavioural Research in Cancer. Melbourne: Anti-Cancer Council of Victoria, 1992.

[28]. Mullins R. Smoking restrictions in some Victorian companies in 1991. In: Victorian Smoking and Health Program. Quit evaluation studies No 6, 1990 - 1991. Melbourne: Victorian Smoking and Health Program, 1992: 147-157.

[29]. National Heart Foundation of Australia (NSW Division). National Heart Foundation smoking in the workplace survey results, 1990, 1991 and 1992 [unpublished report]. Surry Hills: National Heart Foundation of Australia (NSW Division), 1992.

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000

these surveys found that the majority of companies introduced bans without difficulty, and that there had been a rapid acceleration in the numbers of companies introducing policies in the most recent survey year.

Other research in South Australia[30],[31], Western Australia[32],[33] New South Wales[34] and Victoria[35] has estimated the proportion of workers whose workplaces have some kind of ban in force. In South Australia in 1989, 28% of workers experienced total smoking bans at work. In 1991, this had climbed to 53%. In Western Australia, the proportion of workers with total smoking bans has increased from 17% in 1985, to over 70% in 1991. Thirty-three percent of workers in New South Wales were

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[30]. Extent of and opinions about workplace smoking restrictions and effect on cigarette consumption. In: South Australian Smoking and Health Project. Evaluation Report 1989 No 1. Adelaide: South Australian Smoking and Health Project, 1991: 71-83.

[31]. South Australian Smoking and Health Project. Extent of and opinions about restrictions on smoking at work [unpublished report]. North Adelaide: South Australian Smoking and Health Project, 1992.

[32]. Straton RG, Sweeney JC. Smoking in the workplace. Report on a survey among employees. Institute for Social Program Evaluation, Murdoch University. Perth: Smoking and Health Project, Health Department of Western Australia, August 1985.

[33]. The Marketing Centre Pty Ltd. Summary results of a study conducted into employees' attitudes towards smoking in the workplace. Prepared for Health Promotions Department (Western Australia). Perth: The Marketing Centre Pty Ltd, 1991.

[34]. New South Wales Cancer Council Public Opinion Survey. Smoking in the workplace. Sydney: New South Wales Cancer Council, July 1990.

[35]. Borland R. Changes in prevalence of and attitudes to restrictions on smoking in the workplace among indoor workers in the state of Victoria, Australia, 1988-90. Tobacco Control 1992; 1: 19-24.

Source: https://www.industrydocuments.ucsf.edu/docs/frhl0000